UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

FORTEO (teriparatide)

Patient name:_____Medicaid ID #:_____

Prescriber Name:_____Prescriber NPI#:_____ Contact person:_____

Prescriber Phone#:_____Extension/Option:_____ Fax#:_____

Pharmacy:_____Pharmacy Phone#:_____Pharmacy Fax #:_____

Requested Medication:_____Strength:_____Frequency/Day:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY TO (801) 536-0477

CRITERIA:

- Available for the following diagnoses at high risk for bone fracture:
  - Postmenopausal women diagnosed with osteoporosis.
  - Women and men diagnosed with osteoporosis likely caused by systemic glucocorticoid therapy.
  - Men diagnosed with osteoporosis (primary or hypogonadal).
- Quantity limit of one injector every 28 days.

AUTHORIZATION:

24 months with no renewal option.

01/13/11

http://health.utah.gov/medicaid/pharmacy